

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 155

Primary Registration District No. 3127

Registrar's No. 64

49
6
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Wells City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Jasper Chamber Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
in this community _____
years, months or days) 1.5 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper
(c) City or town Wells City
(If outside city or town limits, write "RURAL")
(d) Street No. 506 N. Broadway
(If rural, give location) 0
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Hershel Truman

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Widowed 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: Sept. 22, 1868
(Month) (Day) (Year)

8. AGE: Years _____ Months 0 Days 7 If less than one day _____ hr. _____ min.

9. Birthplace Shellburg Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business _____

12. Name Chas. C. Milled

13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name Fitzmaurice
(City, town, or county) (State or foreign country)

15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Louise Cozart
(b) Address 506 N. Broadway, Wells City

17. (a) Burial (b) Date thereof Oct. 1, 1942
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mount Hope Cem.

18. (a) Signature of funeral director Wells City Burial Co.
(b) Address Wells City, Mo.

19. (a) Sept. 30, 1942 Mrs. Lillie Lyle
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 29th
year 1942 hour 18 minute 0 M.

21. I hereby certify that I attended the deceased from 6-22, 1942, to 9-29, 1942
that I last saw her alive on 9-29-42, 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Compensatory hypertensive arteriosclerosis

Due to hypertensive arteriosclerosis

Due to _____

Other conditions (Include pregnancy within 3 months of death) 99.7

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Manner of injury 2 A.O.

23. Signature Mrs. Lillie Lyle (M. D. or other) 2 A.O.

Address Wells City, Mo. Date signed 10-1-42

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

42-9-782.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by myself.

_____, Registered Apprentice No. _____
working under my personal supervision.

Signed Clayton M. Johnston

Licensed Embalmer No. 3,922

P. O. Address Webb City, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.